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Authorization for Release of Information

Patient's name: _____

I hereby authorize Dr. Andrew Kopelman, M.D. to contact and obtain and/or provide my medical history and other related information from/to the following people:

Name: _____
Telephone: _____

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature: _____
Printed Name: _____
Date: _____

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